STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155224	A. BUILDING 00 B. WING	09/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA HEALTHCARE CENTER	621 WEST COLUMBIA STREET EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. This visit included the investigation of Complaint IN00095663 and Complaint IN00096581. Complaint IN00095663: Substantiated. State/Federal deficiencies related to the allegations are cited at F323. Complaint IN00096581: Unsubstantiated, due to lack of evidence Survey dates: September 12, 13, 14, 15, 16, 19, 20, 2011 Facility number: 000129 Provider number: 155224 AIM number: 100266780 Survey team: Amy Wininger, RN, TC Diane Hancock, RN Census bed type: SNF/NF: 119 Total: 119 Census payor type: Medicare: 18 Medicaid: 92 Other: 09 Total: 119	F0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a post survey re-visit on or after October 12, 2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155224	A. BUILDING 00 B. WING	09/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA HEALTHCARE CENTER	621 WEST COLUMBIA STREET EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Sample: 24 Supplemental sample: 4 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 9/21/11 Cathy Emswiller RN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155224	A. BUILDING 00 B. WING	09/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA HEALTHCARE CENTER	621 WEST COLUMBIA STREET EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to ensure 1 of 2 allegations of abuse were reported to the Administrator immediately, in that the Health Facilities Administrator was not	F0225	**F 225 Investigate/Report Allegations of Abuse** It is the practice of this facility to ensure that all alleged violations involving mistreatment, neglect, or abuse. Are reported to the	10/12/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155224	A. BUILDING 00 B. WING	09/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA HEALTHCARE CENTER	621 WEST COLUMBIA STREET EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	aware of a resident [Resident #81] to resident [Resident #94] encounter involving verbal abuse until the following morning. Finding includes: During the review of a resident to resident abuse investigation [Resident #81 aggressor and Resident #94 victim], the Incident Summary, provided by the HFA [Health Facilities Administrator] on 09/19/11 at 11:00 A.M., indicated, "On 5/19/11 at 1000 [10:00] A.M. this nurse and the ED [Executive Director] were informed of an incident that had occurred on the evening prior..." In an interview with the Director of Nursing and the Health Facilities Administrator, on 09/19/11 at 2:00 P.M., the DoN indicated, "We found it in a behavior meeting the next day, they did not call me that night." The policy and procedure for Abuse Prohibition, Reporting, and Investigating, provided by the HFA on 09/12/11 at 10:30 A.M., indicated, "Policy and Procedure...9. it is the responsibility of every employee of American Senior Communities to not only report abuse situations, but also suspicion of abuse and		administrator of the facility immediately. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The altercation between resident #81 and resident #94 has been reviewed and investigated both residents have received follow up from Social services with no negative psychosocial outcomes noted. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have potential to be affected by alleged defecient practice. · All interviewable residents will be interviewed to ensure that there are no incidents that the Health Facility Administrator is unaware of. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155224	A. BUILDING 00 B. WING	09/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA HEALTHCARE CENTER	621 WEST COLUMBIA STREET EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	unusual; observation and circumstances to his/her immediate supervisor..." 3.1-28(c)		· Staff will be in-serviced over abuse definitions, policy, and reporting. · Cell phone contact for the Health Facility Administrator will be placed in break room, time clock area, stairway corridor, and at all nursing stations to ensure accessability. · ED/designee is responsible to ensure compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Abuse CQI tool will be utilized 3x weekly for one month, weekly for 4 months and quarterly thereafter. Findings from the CQI process will be reviewed monthly and an action plan reviewed monthly as needed for any deficient practices. **Compliance date: 10/12/2011**	
F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure the policy and procedure for abuse reporting and	F0226	**F 226 Investigate/Report Allegations of Abuse** It is the practice of this facility to ensure that all alleged violations	10/12/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155224	A. BUILDING 00 B. WING	09/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA HEALTHCARE CENTER	621 WEST COLUMBIA STREET EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	investigation was followed, for 1 of 2 abuse allegation investigations reviewed, in that the Health Facilities Administrator was not aware of a resident [Resident #81] to resident [Resident #94] encounter involving verbal abuse until the following morning. Finding includes: During the review of a resident to resident abuse investigation [Resident # 81 aggressor and Resident #94 victim], the Incident Summary, provided by the HFA [Health Facilities Administrator] on 09/19/11 at 11:00 A.M., indicated, "On 5/19/11 at 1000 [10:00] A.M. this nurse and the ED [Executive Director] were informed of an incident that had occurred on the evening prior..." In an interview with the Director of Nursing and the Health Facilities Administrator, on 09/19/11 at 2:00 P.M., the DoN indicated, "We found it in a behavior meeting the next day, they did not call me that night." The policy and procedure for Abuse Prohibition, Reporting, and Investigating, provided by the HFA on 09/12/11 at 10:30 A.M., indicated, "Policy and Procedure...9. it is the responsibility of		involving mistreatment, neglect, or abuse. Are reported to the administrator of the facility immediately. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The altercation between resident #81 and resident #94 has been reviewed and investigated both residents have received follow up from Social services with no negative psychosocial outcomes noted. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have potential to be affected by alleged defecient practice. · All interviewable residents will be interviewed to ensure that there are no incidents that the Health Facility Administrator is unaware of. What measures will be put into place or what systemic changes you will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155224	A. BUILDING 00 B. WING	09/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA HEALTHCARE CENTER	621 WEST COLUMBIA STREET EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	every employee of American Senior Communities to not only report abuse situations, but also suspicion of abuse and unusual; observation and circumstances to his/her immediate supervisor..." 3.1-28(a)		make to ensure that the deficient practice does not recur? · Staff will be in-serviced over abuse definitions, policy, and reporting. · Cell phone contact for the Health Facility Administrator will be placed in break room, time clock area, stairway corridor, and at all nursing stations to ensure accessability. · ED/designee is responsible to ensure compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Abuse CQI tool will be utilized 3x weekly for one month, weekly for 4 months and quarterly thereafter. Findings from the CQI process will be reviewed monthly and an action plan reviewed monthly as needed for any deficient practices.	
F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and	F0323	**F323 Free of Accident Hazards/supervision/devices.**	10/12/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155224	A. BUILDING 00 B. WING	09/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA HEALTHCARE CENTER	621 WEST COLUMBIA STREET EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	record review, the facility failed to ensure 2 of 6 sampled residents reviewed for falls, in the total sample of 24, received supervision and assistance devices to prevent the falls, in that alarms and/or seat belts that were care planned were not in place according to the plans. (Residents #87, #94) Findings include: 1. During the initial tour, on 9/12/11 at 9:55 a.m., the Assistant Director of Nurses #2 [ADoN] indicated, when queried, Resident #87 had a history of falls. She indicated the resident had alarms in bed and a seat belt restraint in the wheelchair. She indicated he had no injuries from the falls. Resident #87's clinical record was reviewed on 9/13/11 at 10:20 a.m. The resident's diagnoses included, but were not limited to, senile dementia and essential hypertension. The resident's Minimum Data Set [MDS] assessment, dated 12/9/10, indicated he required total assistance of 2 staff for transfers and was unable to ambulate. The assessment indicated he had a history of falls with only one minor injury. The resident's Fall Prevention Care Plan, dated 6/15/11, included, but was not		**It is the policy of this facility to ensure that the resident's enviroment remains as free of accident hazards as possible; and each resident receives adequate supervision and assistance devices to prevent accidents What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · Resident #87 and resident #94 charts including to but not limited to the fall care plan have been reviewed and revised if indicated. · Observation of Resident #87 and Resident #94 reveals that all fall interventions are in place and functioning.___ **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · All residents have the potential to be affected by this alleged deficient practice. · audit of fall careplans has been completed and cross referenced with the assisgnment sheets. · Observation of residents reveal that fall interventions are in place and functioning. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · nursing staff will be in-serviced over fall interventions. · A fall box will be Implemented at each nursing station containing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155224	A. BUILDING 00 B. WING	09/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA HEALTHCARE CENTER	621 WEST COLUMBIA STREET EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	limited to, the following interventions: Assist of two for transfers, call light in reach, move from bed B to bed A [6/14/11], therapy screen [7/14/11], non-skid footwear, auto-lock breaks, anti-tipping device front on wheelchair, lower bed to floor, bed alarm, bolsters on bed, bed against wall, mattress on floor next to bed, one of the first up in the morning, check resident every hour on night shift and toilet if awake, rear fastening belt restraint, orthostatic blood pressure for 3 days [6/14/11], medication review 6/22/11, 15 minute checks 6/22/11, urinalysis 6/22/11, 3 day sleep pattern 6/28/11, urinalysis 8/14/11, urinal at bedside 8/15/11 Fall Circumstance Reports in the record included, but were not limited to, the following: 6/22/11 0250 [2:50 a.m.], the resident was found sitting on buttocks in front of toilet with hands and feet on the floor. The resident indicated he had crawled "on his butt" to the bathroom. The intervention documented to prevent another fall was "new alarm placed on Res. [resident's] bed, 15 min [checks] initiated." 6/28/11 0445 [4:45 a.m.], the resident was found sitting up on buttocks in front of toilet in bathroom. The resident indicated he didn't have to urinate, but just wanted		safety devices utilized for fall prevention. · Batteries for alarms will be replaced every 3 weeks and as needed throughout the facility. · Alarms will be checked for functioning weekly by management in addition to physician ordered checks by nursing. · DNS/designee will be responsible to ensure compliance. · Non compliance with policy and procedure will result in further training including disciplinary action. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** A Falls CQI audit tool will be completed weekly x 1 monthly, monthly times two, then quarterly thereafter. · The CQI committee will review the audits and action plans will be developed, as needed, to improve compliance. Noncompliance with facility policy and procedure may result in employee education and/or disciplinary action up to and including termination. **Compliance date: 10/12/2011**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155224	A. BUILDING 00 B. WING	09/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA HEALTHCARE CENTER	621 WEST COLUMBIA STREET EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	to get up. The resident's floor was wet next to the bed. The resident was toileted and assisted to bed. There was no indication any alarm was sounding. 7/14/11 0145 [1:45 a.m.], resident was in bed prior to the fall and was found sitting on the floor underneath the bathroom sink. There was no indication an alarm was sounding to alert the staff to the resident being out of bed. The resident was placed on 15 minute checks. 7/14/11 1700 [5:00 p.m.], the resident was found in his room sitting in the floor with bilateral lower extremities extended out in front of him. The resident had been in his room in his wheelchair. The seat belt was documented as off; "Resident unable to describe what happened d/t [due to] advanced disease process." Interventions to prevent further falls included therapy to screen, and 15 minute checks. 8/14/11 0045 [12:45 a.m.], the resident had been in bed and was found sitting on the bathroom floor, straddling the toilet. There was no indication if an alarm was sounding or not. Interventions included 15 minute checks, "at nurses' desk all night." 8/19/11, 0900 [9:00 a.m.], the resident had been propelling himself about in his wheelchair. He stood up from the wheelchair and sat on the floor. The resident was assisted to the wheelchair with 2 staff assisting and "belt applied."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155224	A. BUILDING 00 B. WING	09/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA HEALTHCARE CENTER	621 WEST COLUMBIA STREET EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 9/13/11 at 8:00 a.m., Resident #87 was observed in the dining room in his wheelchair. At 8:10 a.m., he was eating breakfast. The seat belt was not connected, in accordance with the restraint release plan. At 9:45 a.m., the resident was in his room in his wheelchair with the seat belt in place. At 12:00 noon, the resident was in the dining room with the seat belt disconnected. The Director of Nurses indicated, during interview on 9/20/11 at 10:00 a.m., she was unable to determine whether or not alarms had sounded on the occasions the resident was found out of bed. She indicated CNA #1 had been verbally warned, on 8/21/11, for not applying the alarm to Resident #87's bed and the resident was found up in the hallway. She indicated when residents fall it is their pattern to review in morning meeting and inquire as to whether or not the alarms were in use and working. 2. During the initial tour, on 9/12/11 at 10:05 a.m., the Assistant Director of Nurses #2 [ADoN] indicated Resident #94 had experienced a fall in the past 30 days, with a hip fracture. She indicated they were using alarms to alert the staff if the resident got up.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155224	A. BUILDING 00 B. WING	09/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA HEALTHCARE CENTER	621 WEST COLUMBIA STREET EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

Resident #94's clinical record was reviewed on 9/14/11 at 1:07 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, hypertension, dementia, Parkinson's disease, anxiety, and glaucoma. The resident's Minimum Data Set [MDS] assessment, dated 6/14/11, indicated the resident required extensive assistance of one person for transfers and was unable to ambulate.

Resident #94's care plan related to fall risk, dated 8/8/11, included, but was not limited to, the following:
high/low bed in lowest position, pressure alarm in bed and chair, provide assistance for transfers and bed mobility, one assist, refer to therapies for screening, non-skid socks on while in bed, concave mattress 8/21/11, 3 day bowel and bladder tracking 8/25/11, fall matt to side of bed 8/28/11.

Fall Circumstance Reports indicated the resident had a fall on 7/20/11 at 4:20 a.m., where he fractured his hip. The alarm had been sounding and staff were on the way when the fall occurred.

A Fall Circumstance Report, dated 8/21/11 at 3:45 a.m., indicated the resident was found on his knees at the right side of the bed. Interventions were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155224	A. BUILDING 00 B. WING	09/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA HEALTHCARE CENTER	621 WEST COLUMBIA STREET EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	added for the low bed and concave mattress. On 8/25/11 at 4:15 a.m., a Fall Circumstance Report indicated the resident was found sitting on bottom next to the sink in the bathroom. It indicated he had been in bed prior to the incident. The intervention to prevent another fall was "alarm was attached to pad and resident put back in bed. Resident reminded to call for help before he gets up." On 8/28/11 at 2:30 a.m., a Fall Circumstance Report indicated the resident had been in bed and was found kneeling at the bedside. The new intervention was for a "falls mat." On 9/20/11 at 10:00 a.m., the Director of Nurses indicated there was no further information regarding the incidents. She indicated she didn't know what had happened with the alarm on 8/25/11. This federal tag relates to complaint number IN00095663. 3.1-45(a)(2)			
F0332 SS=E	The facility must ensure that it is free of medication error rates of five percent or greater.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155224	A. BUILDING 00 B. WING	09/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA HEALTHCARE CENTER	621 WEST COLUMBIA STREET EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on observation, interview, and record review, the facility failed to ensure it was free of a medication error rate greater than 5%, with the facility having 5 medication errors out of 41 opportunities for error, resulting in a 12.195% error rate. This affected 1 of 1 sampled residents [Resident #138] in a facility sample of 24 and 3 of 3 supplemental sample residents observed for medication pass (Residents #139, #151, #62,), and 3 of 6 nurses observed to pass medications. (RN #1, LPN #3, LPN #1) Findings include: 1. During the observation of the medication pass, on 09/13/11 at 5:35 A.M., RN #1 indicated she was preparing to administer insulin to Resident #139 per sliding scale for an Accucheck [blood glucose monitoring] of 191. RN #1 was observed to prepare Novolog 100/ml 3 units for injection. RN #1 was observed to administer the insulin to Resident #139. Resident #139 was observed lying in the bed on 09/09/11 at 5:35 A.M. The Clinical record of Resident #139 was reviewed on 09/13/11 at 10:00 A.M. The record indicated Resident #139 had diagnosis which included, but were not limited to, Diabetes mellitus."	F0332	**F332 Free of Medication rates of 5% or more.** **It is the policy of this facility to ensure that it is free of medication error rates of five percent or greater.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · Resident # 139,Resident # 151, Resident #138. Charts including to but not limited to physician orders have been reviewed. · Resident #139,#151, and #138 were all assessed and noted to have no negative findings. · Family and Physicians were notified of Medication errors. · Resident # 62 has been discharged from facility___ **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · All residents receiving medications have potential to be affected by the alleged deficient practice. · A medication pass skills validation will be completed on each nurse and qualified medication aide.	10/12/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155224	A. BUILDING 00 B. WING	09/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA HEALTHCARE CENTER	621 WEST COLUMBIA STREET EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The September Physician's Order Recap included, but was not limited to, orders for "Novolog 100 ml/inj inject sub-q per sliding scale: 151-200 = 2 units..." A Care plan dated 03/10/2011 indicated, "Resident had dx [diagnosis] Diabetes, potential for hypo or hyperglycemic reactions...Approaches...insulin/meds as ordered..." In an interview with the DoN [Director of Nursing], on 09/13/11 at 10:10 A.M., she indicated, "...insulin should have been given as ordered..." 2. During the observation of the medication pass, on 09/13/11 at 5:40 A.M., RN #1 indicated she was preparing to administer insulin to Resident #151 per sliding scale for an Accucheck of 208. RN #1 was observed to prepare Novolog 100/ml 5 units for injection. RN #1 was observed to administer the insulin to Resident #151. Resident #151 was observed sitting on the bed on 09/09/11 at 5:40 A.M. The Clinical record of Resident #151 was reviewed on 09/13/11 at 10:05 A.M. The record indicated Resident #151 had a diagnosis, which included, but was not		**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · Licensed nurses and QMAs will be inserviced on policy and procedure of medication administartation. Including but not limited to: following sliding scale insulin delivery, nasal sprays, and mixing medications with the proper amount of fluid. · Licensed nurses and QMAs will have a medication pass skills validation completed · DNS/designee will be responsible to ensure compliance. · Non compliance with policy and procedure will result in further training including disciplinary action. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** A "Medication Pass" CQI audit tool will be completed 3x weekly x 1 month. then quarterly thereafter. The CQI committee will review the audits and action plans will be developed, as needed, to improve compliance. Noncompliance with facility policy and procedure may result in employee education and/or disciplinary action up to and including termination.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155224	A. BUILDING 00 B. WING	09/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA HEALTHCARE CENTER	621 WEST COLUMBIA STREET EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	limited to, Uncontrolled Diabetes Mellitus." The September Physician's Order Recap included, but was not limited to, orders for "Novolog 100 ml/inj inject per sliding scale before meals...:201-250 = 4 units..." A Care plan dated 03/16/2011 indicated, "Resident had dx [diagnosis] Diabetes, potential for hypo or hyperglycemic reactions...Approaches...insulin/meds as ordered..." In an interview with the DoN [Director of Nursing on 09/13/11 at 10:10 A.M. she indicated, "...insulin should have been given as ordered..." 3. During the observation of the medication pass, on 09/13/11 at 8:00 A.M., LPN #2 indicated she was going to prepare and administer medications to Resident #62, with the residents approval, while sitting on the toilet. LPN #2 was observed to prepare Potassium Chloride 30 ml and Miralax 17 grams. LPN #2 was then observed to mix the Miralax with 30 cc of orange juice and then added 40 cc of water. LPN #2 indicated, at that time, that she had mixed the Miralax with "...about 100 cc of liquid." LPN #2 was then observed to administer the Miralax to Resident #62.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155224	A. BUILDING 00 B. WING	09/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA HEALTHCARE CENTER	621 WEST COLUMBIA STREET EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

LPN #2 was then observed to mix 30 cc of Potassium Chloride with 30 cc of orange juice and administer to Resident #62. Resident #62 indicated, at that time, "It burns, very salty, can you get me some water!" LPN #2 gave Resident #62 a cup filled with waster and indicated, "It does have a bite to it, I haven't found anything to mix with that, that it doesn't burn."

The Clinical record of Resident #62 was reviewed on 09/13/11 at 10:15 A.M. The record indicated Resident #62 had diagnoses, which included, but were not limited to, Hypertension and Constipation."

A Physician's Telephone Order, dated 09/08/11, indicated, "Miralax 17 grams, 1 capful in fluid of choice by mouth daily." An additional Physician's Telephone Order, dated 09/11/11, indicated, "Potassium Chloride 40 meq [milliequivalents] daily."

The manufacturer's guidelines for Miralax, provided by ADoN #1 on 09/13/11 at 11:45 A.M., indicated, "...Directions...stir and dissolve in any 4 to 8 ounces of beverage..."

The Nursing 2011 Drug Handbook 31st edition pages 1397-1399 indicated,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155224	A. BUILDING 00 B. WING	09/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA HEALTHCARE CENTER	621 WEST COLUMBIA STREET EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	regarding Potassium Chloride: "...Patient teaching...take with or after meals with full glass of water or fruit juice..." In an interview with the ADoN [Assistant Director of Nursing, on 09/13/11 at 10:15 A.M., she indicated, "...Miralax should be given with 8 oz water and Potassium should be too...". The Policy and procedure for Medication Administration, provided by the DoN on 09/20/11 at 10:45 A.M., indicated, "Purpose...1. To administer medications according to the guidelines set for by the State and Federal guidelines..Procedure: Medication Administration...10. Resident will be given or offered at least 4-8 ounces of fluid with medication... 4. On 9/13/11 at 8:47 a.m., LPN #1 was observed to administer medications to Resident #138. LPN #1 administered Saline Nasal Spray, one spray, in each nostril. Resident #138's clinical record was reviewed on 9/13/11 at 9:00 a.m. The physician's orders, signed by the physician on 8/3/11, indicated, "Saline 0.65% nasal spray, take 2 sprays in each nostril twice daily for sinus congestion." 3.1-25(b)(9) 3.1-48(c)(1)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155224	A. BUILDING 00 B. WING	09/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA HEALTHCARE CENTER	621 WEST COLUMBIA STREET EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0441 SS=D	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155224	A. BUILDING 00 B. WING	09/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA HEALTHCARE CENTER	621 WEST COLUMBIA STREET EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on observation, interview and record review, the facility failed to ensure infection control procedures were followed to prevent potential transmission of infection, in that personal protective equipment was not used when needed, and gloves were not changed and hands washed between soiled and clean activities, during care observations on 2 of 21 sampled current residents, in the sample of 24. (Residents #86, #115) Findings include: 1. On 9/15/11 at 3:00 p.m., CNA #1 was observed in Resident #86's room. She had gloves on, but no gown. She asked, "She's on isolation for what?" No answer was given. She was observed to assist the resident onto a bed pan. After the resident was done, she assisted her off of the bed pan, took the bed pan to the bathroom and disposed of the urine in the commode and rinsed the bed pan. She then took her gloves off, exited the room and went to the resident's former room to get a gown for her. She then assisted the resident to change gowns; the resident indicated she "had a hard time with dripping." CNA #1 wore no gloves handling the soiled gown. She then stated, "I guess she's not in any kind of special isolation, there's no container for soiled clothes." She placed the gown in a plastic bag and exited the	F0441	**F441 Infection Control** **It is the policy of this facility to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** **Resident # 86 was not affected by the alleged deficient practice** **Resident #115 was placed on increased monitoring to rule out infection related to the alleged deficient practice** **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** **All residents requiring isolation have the potential to be affected by the alleged deficient practice.** **Residents requiring perineal care have the potential to be affected by the alleged deficient practice.** **Nursing Staff will complete**	10/12/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155224	A. BUILDING 00 B. WING	09/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA HEALTHCARE CENTER	621 WEST COLUMBIA STREET EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	room. She disposed of the gown in a container across the hall, asking two unidentified CNAs in the hallway, "How long has she been on isolation?" She then returned to the room and washed her hands. Interview with the Assistant Director of Nurses #2 [ADoN], on 9/15/11 at 3:15 p.m., indicated Resident #86 was in contact precautions for Vancomycin Resistant Enterococcus [VRE]. She indicated staff should wear gloves if there might be contact with urine, and maybe a gown, if there was a chance of contamination with the urine. Resident #86's clinical record was reviewed on 9/15/11 at 10:00 a.m. The resident's diagnoses included, but were not limited to, iron deficiency anemia, neurotic disorder, anxiety, hypertension, chronic bronchitis, acute renal failure, and myalgia. The resident had returned to the facility from the hospital, on 9/12/11, with a diagnosis of VRE. The nurse aide assignment sheet, dated 9/14/11, and provided by the ADoN #2 on 9/15/11 at 3:30 p.m., indicated the resident was on contact precautions related to VRE. 2. LPN #2 was observed providing care		**perineal skills validation completed.** **Staff have been in-serviced over infection control policies and procedures including isolation practices.** **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** **Nursing Staff will be in-serviced over policy and procedure of isolation and contact precautions** · Nursing staff will be in-serviced over policy and procedure of perineal care. · Skills validation in regards to perineal care will be completed by nursing staff. · Noncompliance with facility policy and procedure may result in employee education and/or disciplinary action up to and including termination. · Director of Nursing/Designee will be responsible to ensure compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · Infection Control CQI tool will be completed weekly X 4, monthly X2, & quarterly thereafter.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155224	A. BUILDING 00 B. WING	09/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA HEALTHCARE CENTER	621 WEST COLUMBIA STREET EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	to Resident #115, on 9/14/11 at 9:40 a.m. The resident was incontinent of urine and bowel. LPN #2 was cleansing the resident's perineal area prior to doing a treatment. The LPN cleansed the urine and feces from the resident. With the same gloves on, she placed a clean underpad, a clean incontinence brief, handled the clean linens, pillows, side rail, and resident's skin. Resident #115's clinical record was reviewed on 9/13/11 at 8:15 a.m. The resident's diagnoses included, but were not limited to, hepatic abscess, malnutrition, ileus, severe arthritis, diabetes mellitus and hypertension. The resident's Minimum Data Set [MDS] assessment, dated 7/25/11, indicated she was totally incontinent of bowel and mostly incontinent of bladder and required extensive assistance of one staff person for her activities of daily living. 3.1-18(b)(2)		· The CQI committee will review the audits and action plans will be developed, as needed, to improve compliance. Noncompliance with facility policy and procedure may result in employee education and/or disciplinary action up to and including termination. **Compliance date: 10/12/2011**	